TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HCAA MEDICAL GROUP PA

Respondent Name
NATIONAL CASUALTY COMPANY

MFDR Tracking Number
M4-16-1032-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The adjuster for the file at the time . . . her approvals for treatment were verbal and she insured me the bills would get paid as there were no disputes on the patients claim."

Amount in Dispute: $1,512.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10, 2015	Physical Therapy	$1,512.00	$820.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on December 28, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PERCERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 242 – SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS.

Issues

1. Are the disputed services network health care?
2. Did the respondent support the insurance carrier's denial for absence of precertification?
3. What is the recommended reimbursement for the disputed professional medical services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 242 – "SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS." 28 Texas Administrative Code §133.305 defines medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury." Review of Division records finds no information to support that the injured employee is enrolled in a certified health care network. No information was found to support that the disputed services constitute health care delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules. The respondent did not submit any supporting documentation. This denial reason is not supported. Accordingly, this fee dispute will be reviewed pursuant to 28 Texas Administrative Code §133.307 and applicable Division rules.

2. The insurance carrier denied disputed services with claim adjustment reason code 197 – "PERCERTIFICATION/ AUTHORIZATION/NOTIFICATION ABSENT."

   28 Texas Administrative Code §134.600(c)(1) states that the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

   > listed in subsection (p) or (q) of this section only when the following situations occur:
   > (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   > (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care

   28 Texas Administrative Code §134.600(p)(5) states that the non-emergency health care requiring preauthorization includes:

   > physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
   > (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   > (i) Modalities, both supervised and constant attendance;
   > (ii) Therapeutic procedures, excluding work hardening and work conditioning;
   > (iii) Orthotics/Prosthetics Management;
   > (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
   > (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
   > (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
   > (i) the date of injury; or
   > (ii) a surgical intervention previously preauthorized by the insurance carrier;

   The disputed services are physical therapy services listed as requiring preauthorization in subsection (p).

   28 Texas Administrative Code §134.600(f) requires that the requestor shall request and obtain preauthorization from the insurance carrier prior to providing health care listed in subsection (p): "The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission."

Review of the submitted documentation finds that the requestor submitted a copy of the preauthorization request form dated June 23/2015 requesting preauthorization for "PT 3 x 4 wks / 12 visits," with additional listed codes: "97001, 97002, 97110, 97112, 97140, 97530" which was submitted to the insurance carrier by facsimile transmission and notated by hand "approved 12x sessions by adjustor."

28 Texas Administrative Code §134.600(i)(1) requires that the insurance carrier contact the requestor by telephone, facsimile, or electronic transmission with the decision to approve or deny the request within "three working days of receipt of a request for preauthorization." The requestor states that the approval was given by telephone, which meets the requirements of §134.600(i).

The insurance carrier has not presented a response for consideration in this review. The respondent did not present any documentation to refute the requestor's position statement. No documentation was found to support that the insurance carrier issued a denial or adverse determination against the health care provider's request for preauthorization. The respondent did not present any documentation to support denial reason code 242 – "SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS."

The preponderance of the evidence submitted for review supports that the health care provider requested preauthorization and the request was approved by the insurance carrier. Accordingly, the Division finds that the health care provider met the requirement of §134.600(f) by requesting and obtaining preauthorization from the insurance carrier prior to providing the disputed health care. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

3. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

> To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
>
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2015 is $56.20.

Reimbursement is calculated as follows:

- For procedure code 97110, service date July 3, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the Division conversion factor of $56.20 for a MAR of $48.96. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $37.59 at 3 units is $112.77.
- For procedure code 97530, service date July 3, 2015, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.44. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.92 is 0.4876. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.93582 is multiplied by the Division conversion factor of $56.20 for a MAR of $52.59. This procedure has the highest PE for this date. The first unit is paid at 100% for a total of $52.59.
- Procedure codes G8978 and G8979 are functional data reporting codes required on the bill for administrative purposes but do not represent reimbursable services and are not separately paid.

- For procedure code 97110, service date July 6, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the Division conversion factor of $56.20 for a MAR of $48.96. This procedure does not have the highest PE for this date. Payment for each unit is reduced by 50% of the practice expense. The PE reduced rate is $37.59 at 3 units is $112.77.
- For procedure code 97530, service date July 6, 2015, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.44. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.92 is 0.4876. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. This procedure has the highest PE for this date. The first unit is paid at 100%. The sum of 0.93582 is multiplied by the Division conversion factor of $56.20 for a MAR of $52.59.
- Procedure codes G8978 and G8979 are functional data reporting codes required on the bill for administrative purposes but do not represent reimbursable services and are not separately paid.
- For procedure code 97110, service date July 7, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the Division conversion factor of $56.20 for a MAR of $48.96. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $48.96. The PE reduced rate is $37.59 at 2 units is $75.18. The total is $124.14.
- For procedure code 97140, service date July 7, 2015, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.43. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.92 is 0.368. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.80622 is multiplied by the Division conversion factor of $56.20 for a MAR of $45.31. This procedure does not have the highest PE for this date. Payment for the unit is reduced by 50% of the practice expense. The PE reduced rate is $34.97.
- Procedure codes G8978 and G8979 are functional data reporting codes required on the bill for administrative purposes but do not represent reimbursable services and are not separately paid.
- For procedure code 97110, service date July 10, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the Division conversion factor of $56.20 for a MAR of $48.96. This procedure does not have the highest PE for this date. Payment for each unit is reduced by 50% of the practice expense. The PE reduced rate is $37.59 at 3 units is $112.77.
- For procedure code 97530, service date July 10, 2015, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.44. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.92 is 0.4876. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.93582 is multiplied by the Division conversion factor of $56.20 for a MAR of $52.59. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at 100% for a total of MAR of $52.59.
- Procedure codes G8978 and G8979 are functional data reporting codes required on the bill for administrative purposes but do not represent reimbursable services and are not separately paid.

- For procedure code 97110, service date July 13, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the Division conversion factor of $56.20 for a MAR of $48.96. This procedure does not have the highest PE for this date. Payment for each unit is reduced by 50% of the practice expense. The PE reduced rate is $37.59 at 3 units is $112.77.
- For procedure code 97530, service date July 13, 2015, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.44. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.92 is 0.4876. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.93582 is multiplied by the Division conversion factor of $56.20 for a MAR of $52.59. This procedure has the highest PE for this date. The first unit is paid at 100% or $52.59.
- Procedure codes G8978 and G8979 are functional data reporting codes required on the bill for administrative purposes but do not represent reimbursable services and are not separately paid.

4. The total allowable reimbursement for the services in dispute is $820.55. The insurance carrier has paid $0.00. The amount due to the requestor is $820.55.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $820.55.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $820.55, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	April 13, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.